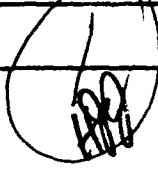
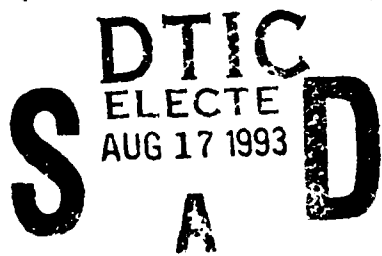



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Implications for Advanced Nursing Practice
in the Use of Therapeutic Touch

by

Linda K. Hogan

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Abstract

Therapeutic Touch is derived from the ancient practice of laying-on of hands. The theory behind Therapeutic Touch is based on the fundamental assumption that there is a universal life energy common to all living things. The art of nursing includes both physiological and psychosocial needs of the patient. The nature of the nurse-patient interaction dictates a heightened sensitivity to the need for human contact and a return to basic caring acts. Therapeutic Touch provides one framework for considering the power of this human interaction as a resource for healing.

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CHAPTER ONE

Introduction

Therapeutic Touch is derived from the ancient practice of laying-on of hands. The theory behind Therapeutic Touch is based on the fundamental assumption that there is a universal life energy common to all living things. Although just beginning to be accepted in Western medicine, this notion of a sustaining life energy has long been a part of Eastern cultures (Macrae, 1988).

"The basic idea is that human beings don't stop at the skin, that we all emit a life force or energy, the organizing factor responsible for healing and regeneration that can be felt radiating from the skin" (Sandroff, 1980, p. 26). In the presence of disease, this energy is depleted and can be boosted by the touch of a healthy individual with an intent to help (Sandroff). The practitioner of Therapeutic Touch begins by relaxing or clearing the mind of outside distractions, followed by personalized hand movements designed to assess and redirect energies to help or heal someone who is ill.

Consideration of Therapeutic Touch brings into focus the major difference between nursing and medical

models of practice. Whereas the medical model allows for direct physical contact within the context of diagnosis and treatment, nursing stems from a more humanistic view which allows more interpersonal touch (Meehan, 1988). "Touch is almost a badge of nursing" (Krieger, 1975a, p. 6). Nurses represent a unique group of individuals who touch people throughout their whole lives: from infancy through the school years, from adulthood through the final stages of death (Weiss, 1979).

We have a problem in that science and technology have encroached on this caring relationship between nurse and patient. "Before the scientific era of health care, helping persons relied on their own presence as a source of helping and/or healing" (Heidt, 1981, p. 36). Health care has become less aware of the effect of human contact and more focused on the use of drugs, machines, computers, and other forms of technology to aid recovery. Attention to equipment and gadgets only serves to make patients feel more insignificant and invisible among the tubes and wires. It is vital that the patient, rather than the bedside accessories, remain the central focus of care.

The art of nursing includes both physiological and

psychosocial needs of the patient. The nature of the nurse-patient interaction dictates a heightened sensitivity to the need for human contact and a return to basic caring acts. Therapeutic touch provides one framework for considering the power of this human interaction as a resource for healing (Heidt, 1981).

Overview

The therapeutic use of hands is a centuries-old practice, but only in the last 30 years has Western medicine acknowledged its potential for healing. Therapeutic Touch is a contemporary version of this ancient art. A deceptively simple-looking act, Therapeutic Touch (TT) is still a little-understood therapy.

This paper is written primarily for the Clinical Nurse Specialist (CNS) who has little or no knowledge of TT or its use in clinical practice. The purpose of this paper is to bring together concepts, principles, and practices associated with TT. Chapter One will briefly examine its history, the influences of Delores Krieger and Dora Kunz on its development and implementation, and the similarities and differences to laying-on of hands. The remainder of the chapter will address TT as a healing modality and its relationship to other types

of touch. Chapter Two will address the guiding principles that underlie the technique and outline the method. Chapter Three will examine TT in research and practice. Finally, Chapter Four will identify ways in which the CNS can utilize TT in clinical practice.

History

Written evidence of the therapeutic use of hands can be traced back some 5000 years through Egyptian hieroglyphics and Assyrian cuneiform writings. Accounts of its use appear in the Bible and church writings of the Middle Ages, as well as the histories of the American Southwest (Krieger, 1986). The modern practice of TT takes this ancient healing technique and pairs it with physical science.

The functional basis of TT requires an acceptance of the concept of a universal life energy. This energy appears under a variety of aliases--prana in Hindu, Ch'i in Chinese (Reisser, Reisser, & Weldon, 1987). Science fiction and the movie industry embraced it in the 1980's with STAR WARS and "The Force".

Delores Krieger/Dora Kunz

Any discussion of TT must include the influences of Delores Krieger and Dora Kunz. Krieger, a nurse, first became interested in the therapeutic use of hands

through her own studies of Eastern religions and later through associations with Hungarian healer Oskar Estebany and Dora Kunz. For several years in the early 1970's, Krieger served as research assistant during Estebany's annual visits to the U.S. to set up temporary healing clinics with Dora Kunz, "a well known observer of paranormal healing" (Krieger, 1975b, p. 785). Later under the guidance of Kunz, Krieger began to experiment with the transfer of human energies and eventually developed the concept of TT out of her experiences (Reisser et al., 1987).

Krieger (1986) felt that the link of being engaged in research and teaching at the university level as she was learning TT fostered an objectivity which facilitated a conscious understanding of the dynamics of this healing practice. Subsequently, Krieger, a professor of nursing at New York University, incorporated the teaching of TT into the university's graduate program (Thayer, 1990). Krieger (1990) estimates that since 1971 she and Kunz have taught the method to over 36,000 health professionals. During the last two decades, Krieger has devoted her time to lecturing and conducting workshops on TT both nationally and internationally, including Japan, China, and

South Africa (Kunz, 1985).

Dora Kunz, like her protege , had a background rich in Eastern philosophies. Raised in the Orient, she began the practice of meditation at the age of five. A recognized clairvoyant and healer, Kunz has applied these abilities to working with physicians in counseling settings and in epilepsy research (Weber, 1985). Her own words best describe these talents: "I was born with a sensitivity enabling me to see and observe the patterns of people's emotional reactions and to relate those to diseases of the physical body" (Weber, p. 303).

According to Kunz and Peper (1985), human energy exists on four different levels or fields: vital, emotional, mental, and intuitive. The vital field corresponds to the physical body. What we do on a daily basis--eating, exercise, rest--enhances or depletes this level. The emotional level involves our feelings, while the mental level is concerned with thoughts. Finally, the intuitive level, the highest level, is insight or the sensing of human need (Hover-Kramer, 1990; Kunz & Peper). Regardless of the terminology or one's belief system, the four levels describe the driving factors behind any nurse-patient intervention.

Laying-on of Hands Derivative

The terms laying-on of hands, Therapeutic Touch, and therapeutic use of hands overlap throughout the literature. Depending on the author, they are synonymous or slightly distinct. Sandroff (1980) describes TT as the "secular version of the religious practice of laying on of hands" (p. 26). From a Judeo-Christian perspective, this distinction may be important to distinguish the practice from biblical connotations.

Payne (1989) observes five ways in which TT differs from the traditional view of laying-on of hands. There is no religious component and the client does not need an acknowledged faith in TT for it to be effective. It is knowledge-based with research studies on its effectiveness and implementation. As a nursing action, intervention results from observation and assessment.

Healing Modality

"Healing is the goal of nursing" (Quinn, 1989, p. 553). Nevertheless, what is healing and how is it different from curing? Healing, from the Old English word haelen, means to become whole (Webster's, 1989). The image that emerges suggests that healing concerns harmony of body, mind, and spirit (Quinn, 1985). Cure,

on the other hand, implies the elimination of the signs and symptoms of disease (Quinn, 1985). Curing is what mainstream medicine offers when it has something to offer; healing is what the individual brings to the situation.

More than hundred years ago, Florence Nightingale (1969) identified the goal of nursing as putting "the patient in the best condition for Nature to act upon him" (p. 75). Her basic premise was that healing is a function of Nature; but the process itself generates from within the individual. The nurse is there to facilitate the process.

The value in TT is that it focuses on the "process of balancing the energies of the total person rather than on the treatment of specific physical diseases" (Macrae, 1988, p. xi). Even if cure is considered a feasible outcome, TT can be an extension of other healing behaviors nurses engage in with their patients, such as listening, holding, or laughter. Regardless of whether death is imminent or recovery is expected, healing, then, is about taking control (Newshan, 1989). It is about empowering the body, mind, and spirit to help us reach that haelen effect--that wholeness.

Types of Touch

Touch is a universal need that crosses all racial, ethnic, and cultural lines. At birth, the faculty to register this primitive sensation already exists. Beginning with the infant's first gropings of hand to mouth, touch becomes one of the most elementary needs for healthy mental and physical development (Krieger, 1975b). Appropriate touch can be used to increase support and trust between individuals and in so doing helps to build relationships. Touch serves to validate what we experience with our other senses. It can influence such physiologic parameters as pulse and respiration. The soothing touch of a hand can indicate acceptance from those around us.

The intent or motivation for touching takes many forms. Task-oriented or procedural touch is done to provide information to the practitioner. This type of touch, such as palpating a pulse or repositioning a patient, is seen as necessary to the patient's physical health. Licensure as health care providers allows this type of touch (Dowd, 1991).

Comforting, or nonprocedural touch communicates a message. The intent appeals to the immediate affective or emotional needs of the patient. These expressive

messages include: security, understanding, respect, empathy, and a willingness to be involved (Dowd, 1991). There is an increased importance for this type of touch in the patient-care setting, especially in critical care units, where reliance on machines and technology have isolated and depersonalized patients. Before the boon of technology in health care, so often what the nurse could best offer the patient were comfort and caring demonstrated by the nurse's presence and touch.

Therapeutic Touch, on the other hand, does not fit the standard descriptors of touch. Is it procedural or nonprocedural, task-oriented or comforting? The literature suggests that it falls on a continuum somewhere between the two extremes.

Certainly prior research findings related to physiologic and affective changes indicate that characteristics of both are present in TT. Its use in pain relief would link it to other types of procedural touch, such as manipulation, in that the outcomes are similar. The sense of relaxation that frequently accompanies TT places the technique in the comfort category.

Impediments to Touch

People seek communication on every level: visual,

verbal, tactile, and sensual. For every message, there is an action, reaction, and interaction between sender and receiver. Touch, alone, is interpersonal communication at its most basic, done with little or no distance between the individuals. Intimate space in the American culture begins at 6 to 18 inches from a person's body. Touching invades this intimate space and becomes of great significance to the message being sent (Hudak, Gallo, & Benz, 1990).

Touch conveys different messages to different people. Whether the touch is perceived as positive or negative depends on what sociocultural and personal meanings we attach to the message. Positive touch requires an understanding of the barriers to touch.

Our past experiences with touch appear to influence how awkward or comfortable we feel with another's touch. Cultural differences and touching habits between family members contribute to the response. In some cultures, touching is part of life; in others it is limited or even discouraged. The degree of intimacy and closeness a child shares within the family further influences to what extent touch is acceptable (Goodykoontz, 1979).

Touch also varies with gender. Behavioral

psychologist Judith Hall uses the term "sports touch" to describe acceptable touch between men (Sensitive, 1992). These are the slapping, hugging behaviors seen at sports events. "It's the closest men can get to show that they care for each other and there is no mistake about what it means" (Sensitive, p. B5).

The health care setting places its own restraints on touch. Dowd (1991) identifies several impediments contributing to the distancing between nurse and patient: scarcity of time, preoccupation with high-tech equipment, inadequate training in caring for critically or terminally ill patients, outside pressures on already overextended health care providers, and the de-emphasis on touch in nursing curricula.

Dowd (1991) further stresses the AIDS scare in all aspects of our lives. The creation of special units devoted to AIDS treatment and fear on the part of some health care workers to care for these patients have both isolated a population most in need of support. Increased reliance on universal precautions and ignorance of the disease and transmission have spilled over into touch behaviors with all patients, on the assumption that any could be HIV positive until proven otherwise.

Obviously, there are no clear cut answers about when and how to touch. We may not accept some of the the Eastern roots of touch as espoused by Krieger, but we must realize the need for touch among patients is real. Cultural and gender barriers to touch are to a certain extent out of our control as health care providers, but we can make a difference in the personal and institutional barriers. Therapeutic Touch reasserts compassion in nursing and is appropriate in all areas to assist the client in the overall coping with being ill.

Summary

This chapter has provided a general introduction to Therapeutic Touch by examining its history, the contributions of Delores Krieger and Dora Kunz in its development, and the similarities and differences to laying-on of hands. Finally, the remainder of the chapter addressed TT as a healing modality and its relationship to other forms of touch. The next chapter will focus on the guiding principles behind TT and aspects of the method.

CHAPTER TWO

Guiding Principles

In the last chapter, Therapeutic Touch was described as a healing modality, based on the concept of a universal life energy. The first three sections of this chapter will examine the theoretical foundations used to explain the TT process and its relationship to other holistic therapies. The last two sections will outline the TT method and its use in conjunction with physical touch.

Major Assumptions

Therapeutic Touch is based on four major assumptions:

1. Man is an open system. An open system is one that maintains itself in a continuous inflow and outflow, constantly exchanging information and energy with the environment (Taber's, 1989).
2. "What we in the West call illness, other cultures would attribute to an imbalance in the ill person's energies" (Krieger, 1990, p. 83).
3. Healing is possible even when cure is not.
4. Therapeutic Touch is not dependent on the recipient's conscious belief in the method.

Rogers' Conceptual Framework

Rogers' conceptual framework in nursing provides the theoretical foundation for Krieger's TT. This theory holds that humans and the environment are energy fields constantly interacting and exchanging energy with one another (Rogers, 1990b). Healing occurs through this simultaneous interaction when "one of the two energy fields actively works in the direction of change" (Miller, 1979, p. 278).

Rogers' nursing model is rather abstract and so requires a broad world view beyond the physical sciences. She defines nursing as a basic science with a fundamental philosophy of wholeness. Within that model, a person is no longer just a person, but a "unitary human being...an irreducible, multidimensional energy field" (Rogers, 1990b, p. 109). Patterns emerge out of the constant interaction of the human and environmental energy fields. Nursing intervention, then, is based on this view of the individual as a whole and directed at the patterns of health and illness that emerge (Malinski, 1990; Rogers, 1990b).

The Science of Unitary Human Beings allows for touch as an extension of energy fields and can include, but doesn't require actual physical contact. From this

perspective, TT is not viewed as strictly a derivative of the ancient practice of laying-on of hands. The healing effects of TT are instead the outcome of the interaction of the nurse and patient energy fields (Meehan, 1990, Quinn, 1983).

Energy Fields

In TT, clients are considered human energy fields. According to Payne (1989), the concept of energy fields in quantum physics is crucial to understanding the effects of TT. Physics examines the properties and interactions of subatomic particles of which humans and the universe are composed. The five senses normally perceive things in the environmental field, including humans, to be solid and separate from one another. Examined on a subatomic level, this solid matter is really pure energy (Payne).

Intrinsic to energy field theory is the concept of interconnectedness within and between humans and the environment (Owens & Ehrenreich, 1991a). If we are beings of energy, this implies that the four energy levels innate to every individual (Kunz & Peper, 1985) are in constant exchange with the environment, including the people in it.

Consider the interpersonal effects of others'

energy fields. Most of us have felt the uneasiness that results when other people, especially strangers, invade our personal space. Nearly everyone can recall an instant dislike or affection for someone, based on no more than a gut reaction. What person has not experienced the profound discomfort of walking into a room so rife with tension that "you could cut it with a knife."

Krieger (1986) cites Eastern philosophy that assumes there is a life force or energy flowing through all living systems. This same ideology propounds that healthy people have an excess of energy, while in illness there is a deficit. Krieger correlates this excess energy with redundancy in the human body--the many compensatory mechanisms for every organ system. Just as organ systems fail when the compensatory reserve is depleted, illness is the result of or can exacerbate this energy deficit.

Drawing again on the principles of physics, the nurse and the client are two interactive energy fields. With TT, the nurse giving the treatment is healthier than the client. Conceivably, this individual with an excess of energy and a strong intent to heal is able to direct this energy to help the client regain balance and

pattern in his or her own energy field (Payne, 1989).

Holistic Focus

Following the concepts of holistic medicine, health and wholeness integrate the physical, psychosocial, and spiritual aspects of an individual. Body, mind, and spirit are inseparable; a change in one implies change in the others. Health care goals are chosen for their appropriateness to the need of the total patient.

Holistic therapies are a natural progression for nurses. The nurse is the one who usually questions the importance of all the systems that interact with the client: the health care experience, home, family, community, and work. This approach addresses "the whole person in a total environment" (Gordon, 1979, p. 416) and facilitates unity between the client and these systems. Kunz (Weber, 1985) uses the concept of wholeness in relation to not only physical energy, but with emotion, thought, and intuition as well. From this point of view, health or wholeness requires a balance among these different levels of energy of equal importance as the balance between the individual and the environment we traditionally know.

Rogers (1990a) challenges us as nurses in the

"creative use of the science of nursing for human betterment" (p. 6). She envisions a new world view embracing holistic trends and emphasizing individualization of services. In her predictions, nursing practice will be characterized by "noninvasive modalities...Therapeutic Touch, imagery, relaxation, and the like" (Rogers, 1990b, p. 111-112). From the perspective of the Science of Unitary Human Beings, Therapeutic Touch is one example of professional nursing practice seeking to strengthen the integrity of body, mind, and spirit.

Method

Therapeutic Touch has four distinct phases: centering, assessment, unruffling, and energy transfer. While distinct, they are not necessarily discrete steps. More often, these steps are performed simultaneously.

The nurse begins by centering, a meditative process of becoming quiet and relaxed, of letting go of outside distractions. Once centered, the nurse assesses the patient's energy field with the hands. Using open palms placed 2-4 inches over the body, the nurse observes for any sensation, such as temperature change. Unruffling follows with the action of smoothing out the energy flow by sweeping motions of the hands.

Finally, the transfer of energy moves energy from the healer to the patient or from one area to another within the patient's body (Krieger, 1986; Thayer, 1990).

Krieger (1986) identifies three conditions which have to be met in order to be effective in the practice of TT. The first requires an examination of one's motivation. The nurse's motivation must lie in the interest of the patient, rather than the needs of his or her own ego. A successful treatment can be a rewarding experience, but the outcome should be motivated by compassion for the client's discomfort, not the need to feed one's ego or sense of self-importance. Kunz (Weber, 1985) stresses that ego should be distinguished from self-confidence. Self-confidence is a sense of certainty, a belief in one's abilities to help another.

A second prerequisite is intentionality (Krieger, 1986). The nurse must fully understand the process of TT and proceed from a strong knowledge base. The intervention is goal directed and follows a plan of action based on assessment.

The last prerequisite according to Krieger (1986) is a willingness to confront oneself. In this author's view, this prerequisite is the most difficult. A willingness to confront oneself requires an examination

of personal belief systems and an openness to complementary healing practices. The practitioner must also come to terms with the idea of being a healer.

Centering

Centering is the act of quieting oneself, physically and emotionally, and focusing on the situation at hand (Joseph, 1990; Thayer, 1990). It means letting go of internal and external distractions, the insanities of daily living, and personal anxieties and irritations. The purpose of centering is to get rid of personal concerns for the moment and be entirely focused on the patient. McGlone (1990) likens this to getting a phone call from a friend in distress. If there are a lot of distractions, we might go to a separate room and shut the door. Centering provides an internal place of quiet that can be summoned at any time (McGlone, p. 81).

Krieger (1986) describes centering as a "place of inner being, a place of quietude within oneself where one can feel fully integrated, unified, and focused" (p. 36). In this centered state, the nurse is more aware of inner sources of healing energy and can consciously direct this energy to assist the person in deficit (Heldt, 1981, p. 32).

Ideally, the nurse will stay on center throughout TT, but should stop and recenter if he or she starts to stray. This is especially important if the nurse becomes tired or feels drained during the process. Centering helps the practitioner avoid consuming the problems and anxieties of the client. For the client, the sense of calm coming from the nurse facilitates relaxation (Macrae, 1988, Newshan, 1989).

There are many variations of centering, frequently taught as a part of relaxation techniques or meditative practices. Centering can be as simple as taking several slow, deep breaths or focusing on some soothing image, or any combination of the two. Meditation and centering may be intimidating concepts to some nurses; what is more important is that the individual be comfortable with any method that promotes relaxation (Macrae, 1988, Thayer, 1990).

Because we are nurses in addition to all the other roles we occupy, we have become accustomed to the constant bombardment with multiple stimuli. Most of us, however, have never learned to deal effectively with multiple requests for our attention. Centering allows us to push these distractions to the edge of our awareness so they do not hinder the healing energy as it

flows through us to the client (Macrae, 1988, p. 24).

Assessment/Listening With the Hands

Phase two, assessment, concerns the scanning of the patient's energy fields with the hands. Even when the patient's problem is localized to a particular area of the body, the person's entire field must be assessed. The practitioner's concern is for balance of the whole, not any particular illness (Macrae, 1988).

Assessment must be done each time the nurse uses Therapeutic Touch. Energy is continually changing; therefore, the needs of the patient can be quite different at every session (Bogulawski, 1979). This energy is felt most easily when open palms are held about 2 to 3 inches above the body (Krieger, 1986). The range is anywhere from 3-5 to 4-6 inches, depending on the author (Macrae, 1988; Thayer, 1990). The practitioner should use the distance that affords the most sensitivity to changes in energy flow.

The entire assessment should be done fairly quickly in no more than 15 to 20 seconds, using the hands in a smooth, head to toe direction. The nurse should not linger and become too self-absorbed in one area, nor move too quickly and miss cues from the energy field. Scanning in a downward direction also helps promote

energy flow (Krieger, 1986; Macrae, 1988).

The idea in the assessment phase is to do more feeling than thinking. Krieger (1979) refers to this as "passively listening with the hands" (p. 660), where the practitioner tunes into the patient's particular energy flow. A healthy energy flow should feel balanced and comfortable in the nurse's hands, evidenced by a soft warmth or gentle vibration and symmetry (Macrae, 1988). Irregularities in the flow might be interpreted as "heat, cold, tingling, pressure, electrical shocks, or pressure" (Krieger, 1986, p. 44).

This sensation of pressure can be simulated using one of Krieger's self-knowledge tests (Krieger, 1986). With the palms facing each other, separate the hands two inches and slowly bring them together to approximately one-quarter inch apart. Repeat the steps, but each time separate the hands by an additional two inches, until they are eight inches apart. Slowly bring the hands together, pausing slightly every couple of inches. Continue these steps for several cycles and observe for a sense of pressure or bounciness. Obviously TT requires proper training, but this kind of exercise provides familiarization and possibly some sense of reality for the process.

Assessment by a single practitioner can be done in several ways (Macrae, 1988). In one, the patient sits on a stool or sideways in a chair, while the nurse sits or kneels at either side. The nurse positions one hand in front of the patient, the other behind the back, and simultaneously moves both hands through the patient's energy field (palms up, 2 to 3 inches from the surface) from the top of the head to the feet. The hand in back is held at hip level as the nurse continues to the feet with the other hand.

In another approach (Macrae, 1988), the patient assumes the same position. The nurse, kneeling or sitting in front, moves both hands parallel to each other through the patient's energy field from head to toe. The process is repeated at the back to the hip level.

Both methods have advantages (Macrae, 1988). With the first, the hands achieve a certain polarity, while the second allows the nurse to check for symmetry. Team treating, or working with another practitioner, is a way to gain both advantages. In the case of a bedridden patient who can turn side to side, one nurse can assess front and back simultaneously.

Validation

Assessment can be validated in one of several ways. Krieger (1986) recommends that whenever possible the nurse observe the patient prior to any contact. Observations serve as useful clues to the patient's condition. Observe for such things as posture, gait, and any outward signs of tension. Note affect, speech patterns, and any attempts to protect or guard any part of the body.

A second objective method (Macrae, 1988; Thayer, 1990) includes written documentation of assessment prior to learning the patient's diagnosis. Both Macrae (1988) and Thayer (1990) caution that TT assessment should not be confused with medical diagnosis. This technique focuses on changes in energy flow rather than a complex battery of tests. As Macrae points out, energy assessment can differ from medical diagnosis. She cites the example of a patient with strep throat who showed evidence of energy blockage over the chest and shoulders.

The assessment can also be compared to that of a second TT practitioner. Krieger (1986) notes that there is usually little discrepancy between two expert practitioners. The most obvious validation is

improvement in the patient's symptoms, since treatment is based on assessment.

Unruffling/Congestion

Unruffling is the process of smoothing or decongesting the energy flow (Reisser et al., 1987). When the TT practitioner notes any irregularities during assessment, this is interpreted as stagnant energy. The purpose of unruffling the field serves to get this energy moving through the body and clear the way for the last step of energy transfer (Thayer, 1990).

Therapeutic Touch practitioners, regardless of their cultures, tend to use similar phrases to describe the sensations associated with stagnant energy: "heat, cold, tingling, pressure, pulsations, or electrical shocks" (Krieger, 1986, p. 52). Krieger (1986) consolidates all these cues under the terms pressure or congestion.

Macrae (1988) goes a step further and divides the sensations into four broad categories of energy congestion. Loose congestion feels like pressure or heat. This type can often be found near wounds or infection, but may be observed where there is no known physical problem. Tight congestion occurs near heavily congested or blocked areas. Associated with chronic

problems, this type might feel cold or be lacking of any sensation. Deficit can be felt as a drawing or pulling sensation and is usually found near any blocked area. The fourth type, imbalance, occurs when an area of the energy field is not working in harmony with the whole, such as in an area of organ damage, and may feel like tingling. Macrae cautions that in actual practice these sensations or cues tend to overlap and blur.

Energy congestion is cleared using gentle, sweeping, downward motions of the hands (Macrae, 1988). This freeing of energy does not last long, but facilitates the transfer of energy between nurse and patient. Krieger (1986) suggests that unruffling be limited to no more than 2 to 3 minutes with children, the elderly and debilitated, and in treating the head, because of heightened sensitivity to manipulations of energy.

Energy Transfer

Transfer of energy is dependent on the understanding that the nurse and patient are energy fields, constantly exchanging energy with the environment around them (Rogers, 1990). Directing energy can be done in either of two ways, from the nurse to the patient or from one area of the patient's body to

another (Krieger, 1986). The channeling from nurse to the patient reflects back on the Eastern beliefs that healthy people have an excess of energy and one person can act as a conduit of energy for another (Krieger). When transferring energy, it is imperative that the TT practitioner maintain the intent to be a conduit for universal life energy, so as not to deplete his or her own energy (Macrae, 1988).

The sensations felt in the hands during assessment serve as the guide for treatment, with the intent to correct any imbalances so that the energy field is symmetrical again (Reisser et al., 1987). An area which felt cool needs to be warmed, an area of tingling quieted, a cue of pressure mobilized, pulsations moderated, and so forth (Krieger, 1986). These changes are brought about as the practitioner creates the change in his or her mind and then directs the image through the hands (Reisser et al.).

The choice of imagery depends on the practitioner. Macrae (1988) finds it helpful to visualize the energy as a stream of light flowing through her and going to the patient. Krieger (1986) prefers to conceptualize energy in terms of color. In her experience, the color blue will sedate, red will stimulate, and yellow will

energize.

Energy transfer appears to be more involved than merely channeling energy. In addition to directing energy, the practitioner needs to know how to regulate the flow in relation to the patient's particular needs (Krieger, 1986). Macrae (1988) pointed out that irregularities in energy flow tend to blur and overlap. There may be situations where one area of the patient's energy field may need to be energized, while another needs to be calmed.

To initiate energy transfer, the nurse, still in a centered state, places both hands over the congested area (Thayer, 1990). The patient is considered an active energy field, and so pulls in energy according to his or her condition or deficit at the time of the treatment (Macrae, 1988). This stage of TT is an ongoing reassessment and treatment phase, since blocks in the energy flow can move and resurface in another area (Macrae).

Duration of TT depends on the patient's response (Boguslawski, 1979; Thayer, 1990). The practitioner stops when there are no more cues of blockage or after monitoring for changes in the patient's tolerance level. Boguslawski (1979) advises caution with infants and

children, because of their developing energy fields and urges that these groups not be treated by nurses just learning Therapeutic Touch.

Combination With Physical Touch

Therapeutic Touch is typically thought of as a non-contact healing intervention, but physical touch is frequently incorporated into the treatment. Clients need to be as relaxed as possible before the procedure, since tension tends to decrease the ability to absorb energy (Boguslawski, 1979). A simple shoulder and back massage, combined with a few deep breaths, may facilitate relaxation.

The practitioner may use physical touch during unruffling to help mobilize congestion (Macrae, 1988). In unruffling, congestion is directed downward where it clears through the feet. If a person's feet are blocked, as evidenced by coldness, then congested can't be removed. Macrae (1988) exerts gentle pressure with the fingers under the arches to stimulate energy flow and warm the feet.

Summary

This chapter has focused on Therapeutic Touch as a holistic nursing strategy that can be used to promote the well-being of body, mind, and spirit. According to

concepts advanced by Martha Rogers, healing occurs through the simultaneous interaction of human and environmental energy fields. In a state of health, energy flow is balanced, while in illness there is a deficit. With sweeping movements of the hands a few inches from the patient's body, the TT practitioner scans and directs energy flow to facilitate healing and restore wholeness within a diseased system. The next chapter will examine TT from the patient's perspective, research to date on the effects of TT, and its use in specific patient populations.

CHAPTER THREE

Therapeutic Touch in Research and Practice

The last two chapters addressed the basic concepts essential to an understanding of Therapeutic Touch as a healing process and nursing intervention. This chapter will focus attention specifically on the patient. The first section will consider subjective experiences of patients and expected observable responses. The second section will detail the contributions of nursing research to the study of the physiologic effects of TT. Finally, the last section of the chapter will discuss the use of TT as an adjunctive therapy in the treatment of specific patient populations.

The Patient's Experience

Subjective

Relaxation commonly follows Therapeutic Touch (Krieger, 1986; Macrae, 1988). Most people experience the familiar signs: a sense of calm, heaviness and warmth in the hands and feet, and a general release of tension. Others report feeling warmth and tingling over the area where the treatment was concentrated or that they actually felt the congestion as it traveled through the body. A few patients occasionally have transient nausea as the nurse directs congestion down the body

over the abdomen. Those who present with chronic pain frequently report a temporary decrease in symptoms (Owens & Ehrenreich, 1991a), though this may be more an effect of relaxation.

Sometimes patients do not feel anything in particular, but will be aware of feeling better or having more energy the next day (Boguslawski, 1979). The fact that any of these patients felt better after treatment could be explained as the placebo effect; however, placebo has been observed to help in over 30% of illnesses (Krieger, 1979).

Objective

The subjective response depends entirely on the patient's perspective of TT. Subjective data can be influenced by placebo, faith, or even a desire to please the nurse. Complete relaxation, however, is an observable, characteristic response that has been referenced throughout the TT literature.

Krieger (1986) estimates that over 90% of patients exhibit the relaxation response. She has identified several signs the nurse can expect to see post-treatment: slow, deeper respirations, a deepening of the voice, audible sighs, and flushing of the skin from peripheral vasodilatation. The literature is unclear as

to why this occurs. It is possible that the client, like the practitioner, experiences a sense of calm, which invokes an alpha state and triggers the relaxation response (Krieger, 1979).

Past Research on Physiologic Effects

An examination of the published literature indicates that support for the practice of TT is at best, weak. A 10-year retrospective search of the computerized database, Computerized Index of Nursing and Allied Health Literature (CINAHL) revealed 72 articles on TT. Of the 72 articles, less than 10 were related to the physiologic and psychosocial effects.

Four of the studies considered the relationship between TT and stress reduction, one of which examined only case studies. The remainder of the literature focused heavily on the history and method and applications to particular patient populations.

The earliest research specific to TT dates back 20 years. In 1973, Krieger (cited in Krieger, 1975b) looked at the effect of the therapeutic use of hands on hemoglobin. Her study found an increase in Hgb values post-treatment in the 43 volunteers in the experimental group, compared to no change in the control group.

Several studies focused on anxiety levels of

inpatients. Heidt (1981) compared cardiovascular patients and found that those who received TT had lower post-test anxiety scores than either of two groups who received casual or no touch. Quinn (1983) found similar results between cardiovascular patients who received TT versus a mimic treatment.

Kramer (1990) extended this research to children 2 weeks to 2 years old. In her study, stress reduction was measured by pulse, skin temperature, and galvanic skin response. The results demonstrated that TT decreased the time needed to calm children after stressful procedures.

None of these studies can be interpreted as proof of the transfer of energy between the nurse and patient. The reality of an energy exchange between two human beings remains untested and points to a direction for future research.

This author has identified several "red flags" that need to be addressed in order to further research in TT:

1. The definition of TT is not specific across the nursing community. Several authors use the term strictly in relation to comforting touch behaviors, such as hand holding and massage.

2. Therapeutic Touch is viewed too often as

purely a relaxation therapy, rather than in the context of energy transfer.

3. Touch and TT are conspicuously absent from nursing curricula.

4. Therapeutic Touch has not been embraced by any organized research body; however, this is expected to change. The National Institutes of Health have formed an advisory panel on unconventional medical practices and allocated \$2 million to fund research in such areas as homeopathy and TT (Nurse Healers, 1993).

Therapeutic Touch in Practice

Adjunct to Clinical Therapy

Too often in the effort to cure the patient, the human experience of illness or injury is lost. Modern medicine has done well in treating many illnesses, but has not gone far enough in creating an atmosphere of wholeness. Traditional medical therapies are not perfect; they frequently leave the patient exhausted and in pain. Adjunctive therapies offer a holistic approach to health and put the emphasis back on the patient, rather than the disease.

Therapeutic Touch is not an alternative to medicine, but can be a complementary addition to standard nursing and medical practice. It is a way to

make the patient feel more relaxed and comfortable. Furthermore, even if mainstream medicine never embraces TT, it might prompt nurses to again use the hands and other caring behaviors to reduce patient stress and ease the discomforts of living, rather than just the voice or high-tech equipment.

Specific Uses

Pain

There has been a shift toward nonpharmacologic methods of pain relief, brought about primarily through research, particularly in the management of chronic pain (Carr, 1990). Adjunctive therapies have been a part of pain management for several years. Though pharmacologic methods are still the main strategy for pain relief, numerous non-invasive interventions are available. Most of these fall into the category of relaxation techniques.

Often, nonpharmacologic interventions are initiated because clients are not completely responsive to or are unable to tolerate conventional methods. Despite the fact that adjunctive therapies may not result in complete elimination of pain, their benefit lies in helping the patient gain a sense of control over chronic pain. Usually these methods reduce the need for

analgesia in respect to both dosage and frequency (Owens & Ehrenreich, 1991a).

Therapeutic Touch, with or without massage, helps to promote relaxation in chronic pain patients. People who regularly follow some form of relaxation therapy find that it helps them identify stressors that trigger pain and modify the intensity before it reaches its worst level. One feature that makes TT attractive for chronic or acute pain is that it does not require physical touch. In situations where the patient can't tolerate physical contact, such as with burns, feels uncomfortable being touch, or is in a critical care unit surrounded by lines and tubes, TT offers a useful adjunct to pharmacologic methods of pain control (Owens & Ehrenreich, 1991b).

Premature Infants

Hospitalization for premature infants can last for months, sometimes years. Intubation and mechanical support can last just as long. Almost every intervention is stressful and is infrequently balanced by parental or caregiver touch. The literature is inconclusive as to whether these infants are overstimulated or sensory deprived. The benefits of soothing touch are well documented: calmer infants,

earlier extubations, and greater weight gain (Field, 1990). Babies respond well to Therapeutic Touch; the key is use a gentle technique for a very short period of time (Krieger, 1986).

Children

Therapeutic Touch for children is similar to adults, but just as with medication, they require shorter, gentler treatments (Krieger, 1986). Kramer (1990) found that Therapeutic Touch reduced the time needed to calm children after stressful procedures. Krieger (1986) has used the technique to lower elevated temperatures and for pain relief. Parents can also be taught the method to help their hospitalized child feel less anxious and overwhelmed (Thayer, 1990).

Rehabilitation

Creative problem-solving is the hallmark for rehabilitation nurses. Patients who are challenged by the activities of daily living require flexible and innovative care strategies. Therapeutic Touch can be useful in relieving pain, decreasing anxiety, and dealing with needs related to disability, loss, and prolonged hospitalization (Payne, 1989). Positive responses noted from case studies include clearer speech in certain types of aphasia, improvements in sleeping

and bladder control, and more open verbalization of feelings related to disability (Payne).

Persons With AIDS

The issues of the media and increased reliance on universal precautions have generated a heightened awareness of the needs of patients with AIDS. Adjunctive therapies can be especially helpful in this population where the medical treatment protocols change daily. Therapeutic Touch has been found useful for the congestion of pneumonia, abdominal cramps, fever, pain associated with neuropathies and esophagitis, and the anxieties brought on by the tremendous stress. As an extension of compassion, TT may also help bridge the barriers to touch so often wrought by the AIDS hysteria and universal precautions.

Therapeutic Touch as an adjunctive therapy need not be limited to these particular problems and illnesses. The desire to be free of pain and to be able to deal with the anxieties of disease are universal. The potential effectiveness of independent nursing interventions is well documented. What is needed is an openness to complementary healing practices and a more creative use of the nursing process.

Summary

This chapter has focused on clinical applications of TT, from the standpoint of nursing research and as an adjunctive healing therapy to standard nursing and medical practice. The next chapter will examine the role of the CNS in the utilization of TT in advanced nursing practice.

CHAPTER FOUR

Roles of the Clinical Nurse Specialist

The role of the Clinical Nurse Specialist (CNS) is multidimensional and may be addressed within a framework of responsibilities, competencies, or defining characteristics. All of these combine to demonstrate the unique contributions the CNS makes in caring for complex patients and families. This chapter will examine implications for advanced nursing practice in the use of Therapeutic Touch from the perspective of the five subroles of the CNS as delineated by the American Nurses Association (1986): practitioner, educator, consultant, researcher, and administrator. Successful implementation of TT into clinical practice, as outlined in this chapter, does not require that the CNS be a TT practitioner; however, this individual should have an understanding of the guiding principles and potential value of TT as a complementary healing practice.

Practitioner

As an expert practitioner, the CNS takes a comprehensive approach to nursing practice to improve patient care outcomes and develop and maintain a competent care team (ANA, 1986). The CNS views the client as part of a larger system and evaluates each as

an integrated whole--inseparable of body, mind, and spirit. Health care goals and clinical decision-making are based on the needs of the total patient.

The CNS understands the goal of nursing practice is to put the patient in the best condition for healing to take place. The CNS recognizes that adjunctive therapies, such as TT, are not alternatives to traditional medicine, rather an extension of healing modalities. Just like nutrition, chemotherapy, or surgery, complementary therapies are keys that unlock the hold of disease and allow the patient to achieve a sense of well-being.

In the practitioner role, the CNS has an obligation to explore with the client all interventions that enable this individual to gain a sense of control over disease. Where mutual agreement exists, the CNS may recommend adjunctive treatments within the therapeutic relationship. When the CNS is not a practitioner of TT, this relationship authorizes referral to such providers. TT does not require a conscious belief in its efficacy, but allows the patient to be a full participant in recovery. Even if it can be argued that TT is a form of stress reduction rather than energy transfer, it puts the patient in a relaxed state so that his or her own

natural healing powers can go to work.

Practice issues surface as to what is the appropriate context in which to learn TT. Because other health care professionals, and to a certain extent the public, look to the CNS for guidance, the CNS must be prepared to address concerns regarding training and the skepticism surrounding many adjunctive therapies. Meehan (1990) recommends TT be taught as part of undergraduate or graduate nursing curricula or in a continuing education program of a nursing school or health care agency nursing department. The CNS, whether a practitioner of TT or in a referral capacity, should have a basic understanding of Rogers' theoretical framework, understand arguments for and against TT in nursing practice, and be able to discuss TT in terms familiar to patients and other staff members.

The CNS in private practice can easily define the extent of TT in patient-focused care; however, TT concepts and applications in a hospital setting should be clarified with administration, colleagues, and staff nurses to gain their support. Furthermore, the CNS must discuss TT with a patient's physician so there is no misunderstanding of its use or the CNS' intent.

A secondary benefit can be derived from the use of

TT, apart from the needs of the patient. The CNS who regularly practices centering to prepare for a TT treatment or as meditation, may note the personal rewards of stress reduction. Its continued use as an extension of relaxation techniques may protect the CNS from burnout and the constant demands of the role. In addition, the CNS who can separate mentally and emotionally from the distractions of a busy unit is better attuned to the holistic needs of the patient and better able to communicate compassion and a desire to help.

These suggestions are not meant to limit or dictate the CNS practitioner role in relation to the use of TT. Definition of the role depends on the individual and personal philosophy on the use of adjunctive therapies in direct clinical care. What is important is that the CNS be open to treatment modalities that facilitate healing.

Educator

Education is a traditional role of the CNS. By virtue of advanced practice, the CNS extends this educational role to clients, families, colleagues, and nursing staff (ANA, 1986). The CNS may serve as a resource person, preceptor and role model to staff

nurses and nursing students, or member of a staff development department. The CNS, involved in direct patient care, may use this time to assess and correct knowledge deficits and disseminate information. The applications are varied and frequently occur simultaneously.

Any of these situations affords an opportunity to teach and reinforce TT as a useful patient care adjunct. The CNS can use continuing education to acquaint staff on its use, either by developing a new program or incorporating TT into existing programs. Grand rounds and medical staff meetings provide an avenue to orient physicians. The CNS can volunteer to precept graduate students, thereby introducing TT in the clinical setting. Direct patient care allows the CNS to explore complementary therapies with the patient. Community-focused events, such as health promotion campaigns, provide still another outlet for the CNS to introduce TT to a wide variety of populations.

The CNS in a nursing faculty position is one mechanism to share clinical practice experiences using TT and to educate fellow instructors and students on its use and benefits. This position also affords the CNS a setting in which to contribute to the theoretical

framework of TT. The continuing acceptance of TT in clinical settings necessitates that theory development be an ongoing process to expand the relationship of theory to nursing practice.

In response to the recognition that conventional methods may not be totally adequate to promote healing, nurses are becoming increasingly skillful in the practice of adjunctive therapies. Those with expertise can teach others. Those who are not practitioners can facilitate an awareness of complementary healing practices by making information available on learning opportunities and implementation strategies.

Consultant

The major role of the CNS as consultant is to introduce new information, skills, and perspectives into the clinical setting to help staff keep abreast of changing conditions. The goal of nurse consultation is to facilitate client-centered problem solving and positively impact patient care outcomes. The client may be a patient, family, colleagues, or staff members (ANA, 1986). Consultation may be formal or informal. The consultation role frequently overlaps with those of practitioner and educator.

As previously discussed, TT has implications for

many patient populations. The CNS may be the first resource for this and other adjunctive healing therapies. Staff nurses who are familiar with TT will probably direct inquiries to the CNS for information and resource materials. The CNS may be in the best position to locate and access this information.

If the CNS is a TT practitioner, this individual should have a system in place for intrafacility referrals. If in private practice, the CNS may choose to advertise in nursing journals, consider direct solicitation, or list with an organization such as Nurse Healers-Professional Associates, a not-for-profit group whose purpose is to promote healing modalities. This same organization can assist the CNS in locating an outside consultant to work with in house patients, by use of its published directory of TT practitioners and those of other healing modalities.

The CNS may be called upon to collaborate in developing policy guidelines and Quality Assurance standards for TT. Expert knowledge and visibility place this individual in a prime position to influence organizational acceptance and understanding of TT. Consultation, both formally and informally, provides numerous opportunities to introduce the topic of TT as

an adjunct to interdisciplinary patient care.

Researcher

The problems of research to support TT have already been identified. The research process should serve as a vehicle to improve clinical practice. A primary concern for the CNS at this point should be to follow closely the way in which the National Institutes of Health plan to address complementary healing practices, such as TT.

Because research in this area is still somewhat haphazard, the CNS has a opportunity to make significant contributions to a growing body of knowledge. Documentation of any form of significant touch and the patient's response can be a basic first step. Reading documented effects may generate some interest in its healing potential (Krieger, 1975a).

The CNS is an ideal position to identify practice issues which should be pursued with research, either through personal observations or those concerns raised by staff nurses. Both the CNS and staff nurses have firsthand knowledge of the patient's response to traditional approaches to care and with proper orientation, staff nurses can learn to convert this to nontraditional approaches. Staff nurses can be

encouraged to start a journal club to assist in their understanding of research and its impact on their practice. Depending on experience and motivation, the CNS may supervise such clubs, work with staff to initiate research, duplicate existing research, or participate in data collection for other researchers. The CNS may also look to university nursing faculty and such organizations as Nurse Healers-Professional Associates for guidance in practice issues related to TT.

Administrator

As an administrator, the CNS becomes responsible for the design and implementation of clinical services (ANA, 1986). This role affords the CNS the opportunity to integrate both leadership and practice competencies and may still allow for the roles of consultant, educator, and researcher.

In the administrator role, the CNS is in a position to support the implementation of TT and other adjunctive therapies into clinical practice. The CNS administrator acts as a change agent to create a climate in which healing modalities are as much a norm as traditional nursing models, thereby both welcoming and encouraging their practice.

Within this context, the CNS administrator ensures that standards of practice and Quality Assurance monitoring tools are developed to guide implementation of TT. This individual supports the efforts of Clinical Nurse Specialists and staff nurses in research to build the knowledge base of TT and directs that continuing education be a priority in preparing clinical staff in the use of TT. All actions are focused at a comprehensive and holistic approach to patient care.

Summary

The role of the Clinical Nurse Specialist is multidimensional and demonstrates the unique contributions of the advanced practitioner in the implementation of Therapeutic Touch into clinical practice. Definition of the role depends on the individual's personal philosophy on the use of adjunctive therapies in diverse patient populations. The CNS who recognizes the importance of healing modalities can positively influence patient care outcomes.

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